NOTIFICATION OF MAXIMUM MEDICAL IMPROVEMENT/FIRST IMPAIRMENT INCOME BENEFIT PAYMENT

DATE:

TO: **[NAME OF INJURED EMPLOYEE]**
[ADDRESS]
[CITY, STATE, ZIP]

RE: **[DATE OF INJURY]**
[NATURE OF INJURY]
[PART OF BODY INJURED]
[EMPLOYEE SSN]
[CLAIM #]
[CARRIER NAME/TPA NAME]
[CARRIER CLAIM#]
[EMPLOYER NAME]
[EMPLOYER ADDRESS]
[EMPLOYER CITY, STATE, ZIP]

You have been certified to have reached Maximum Medical Improvement (**MMI**) and had an Impairment Rating (**IR**) assigned. Entitlement to Impairment Income Benefits (**IIBs**) begins the day after the date you were certified as having reached MMI. For each percentage point of the impairment rating, you will receive 3 weeks of benefits. The amount of your IIBs benefit is based on 70% of the reported Average Weekly Wage of (***$$$***).

_____ We have received a report from Dr._____(copy attached) certifying that you have reached MMI on (***date of MMI***) and have been assigned a whole body IR of 0%. Based on this report, you are not eligible for additional income payments of any type. You remain entitled to necessary medical benefits related to this injury.

_____ We have received a report from Dr. _____(copy attached) certifying that you have reached MMI on (***date of MMI***) and have been assigned a whole body IR of _____%. Based on this report you will no longer be eligible for TIBs, however, beginning (***date after MMI***), you will receive _____ weeks of IIBs at the rate of $_____ per week less any allowable reductions. These benefits will end approximately _____. You remain entitled to necessary medical benefits related to this injury.

_____ We are disputing the IR of _____% certified by Dr._____ (copy attached) and have made a reasonable assessment of _____% impairment. Based on this assessment, we will pay IIBs for _____ weeks at the rate of $_____ per week pending the resolution of the IR dispute less any allowable reductions. You remain entitled to necessary medical benefits related to this injury.

_____ We have received a report from Dr._____(copy attached) certifying that you have reached MMI and you do not have any permanent impairment as a result of this compensable injury. Based on this report you are not eligible for any income benefits of any type. You remain entitled to necessary medical benefits related to this injury.

_____ Based on a benefit accrual date of (***date of the 8th day of disability***) we have determined you have reached statutory MMI. In the absence of an IR certified by a doctor, we have made a reasonable assessment of _____% and will pay IIBs for _____ weeks at the rate of $_____ per week pending the resolution of the IR dispute less any allowable reductions. You remain entitled to necessary medical benefits related to this injury.

If you are expected to be paid benefits for a period of eight weeks or more, you may request that we make benefit payments by electronic funds transfer directly to your bank account. Also, you may request that we change your IIBs to a monthly payment.

Explanatory Comments: (free text for explanatory comments)_____
_____

If you do not agree with this certification of MMI and/or IR you have 90 days from the date you receive this notication of MMI and/or IR to file a dispute with the Texas Department of Insurance, Division of Workers' Compensation by contacting the Division office handling your claim at 1-800-252-7031.

If you are interested in having your payments made directly to your bank account or do not agree with the finding of MMI, IR certified by the doctor, or the amount being paid please contact me:

Adjuster's Name: _____
Toll Free Telephone #: _____
Fax #/E-mail Address: _____

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. You can contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

Cc:

INSTRUCTIONS:

Notification of Maximum Medical Improvement and Impairment Rating (DWC FORM PLN-3), Rule 124.2(e)(1),(4), and (5), and (f); (MTC: IP, CB,RB)

This is a letter for the Notification of MMI/IR and will serve as a notice of payment or non-payment of 030 (IIBs). This letter may be used if the payment of 030 (IIBs) benefits is the first payment of income benefits (IP), the change from TIBs to IIBs (CB), or when IIBs are being reinstated after the payment of TIBs has been suspended (RB). This notice should be used to report to the injured employee/representative the payment of impairment income benefits.

THIS PLN IS NOT TO BE USED AS A NOTICE IF THE EMPLOYEE HAS REACHED STATUTORY MMI AND THE CARRIER IS NOT ASSESSING AN IMPAIRMENT RATING. REFER TO DWC FORM PLN-9 SUSPENSION OF BENEFITS.

THIS FORM SHALL BE USED TO REPORT THE CONVERSION OF INCOME BENEFITS FROM TEMPORARY INCOME BENEFITS TO IMPAIRMENT INCOME BENEFITS.

EACH OPTION IS EXCLUSIVE IN ITSELF AND YOU SHOULD CHOOSE OR MARK ONLY ONE OPTION.

1. Check the box next to the appropriate reason for the conversion/suspension of income benefits. **You may provide only the appropriate reason for the conversion. All other reasons may be deleted form the body of the notice.**

2. Fill in all required blank fields for the selected option.

DO NOT SEND THIS LETTER TO THE TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION